U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 November 2005

In the Matter of:

CLARENCE E. WHALEN,
Claimant,

CASE NO: 2003 BLA 5716

v.

JIM WALTER RESOURCES,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

Roderick Graham, Esquire
for the Claimant

Thomas J. Skinner, IV, Esquire
for the Respondent Employer

Before: Edward Terhune Miller
Administrative Law Judge

DECISION AND ORDER - DENIAL OF BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 (hereinafter referred to as "the Act"), 30 U.S.C. § 901 *et seq.*, and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On April 11, 2003, this matter was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a hearing. (DX 188)[1]. A formal hearing in this matter was conducted on November 18, 2004, in Birmingham, Alabama. The Claimant was present and represented by Attorney Roderick Graham. Attorney Thomas J. Skinner was present on behalf of the Employer. The record was closed at that time and post-hearing briefs were submitted. The decision that follows is based on all relevant evidence of record.

ISSUES

The issues in this case are:

1. Whether the Claimant has pneumoconiosis as defined in the Act and regulations;

2. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether the Claimant is totally disabled;

4. Whether the Claimant's disability is due to pneumoconiosis;

5. Whether the evidence establishes a change in an applicable condition of entitlement pursuant to § 725.309 (d).

(DX 22)

Based upon an appropriate analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The Claimant, Clarence Whalen, testified that he first started working as a coal miner in February 1955. TR 14. He worked at Maxine Mines for approximately 10 years, primarily as a shuttle car operator. TR 15. In or around 1965, the Claimant began working at U.S. Pipe and Foundry. TR 16. This employment continued until 1971. TR 17. Thereafter, the Claimant worked as a federal coal mine inspector for twelve years,

[1] In this Decision and Order, "DX" refers to the Director's exhibits and "EX" refers to Employer's exhibits, and "TR" refers to the transcript of the hearing.

prior to sustaining a disabling shoulder injury. TR 17-18. A prior finding by the Deputy Commissioner's Memorandum of Conference found 16 years of coal mining employment. The parties have not disputed this finding. As it is consistent with the Claimant's testimony, I find that the Claimant worked at least 16 years as a coal miner as defined by the Act.

The Claimant testified that during his time working in the coal mining industry he was exposed to substantial amounts of coal dust. Specifically, as a federal coal mine inspector, the Claimant was exposed to nearly all areas of the mine and mining processes. He testified that he smoked at most a pack of cigarettes a day for approximately two years, around 1955-1956. Since then, he has not smoked tobacco of any kind. TR 26-27.

The Claimant testified that he first started having respiratory problems while still working in the mines. He testified that he had difficulty breathing and frequently coughed up coal dust. TR 28. More recently, the Claimant has been treated by his family physician, Dr. Hudson, who prescribed two separate breathing medications. TR 20. He testified that he is unable to walk up an incline, has sleeping problems, and is unable to bathe or dress by himself. TR 37. In addition to his respiratory problems, the Claimant testified that he was diagnosed with Parkinson's Disease in 1973. TR 33. His medical records also document significant coronary artery disease.

Procedural History

The Claimant first filed an application for black lung benefits on January 21, 1980. At a conference before the Deputy Commissioner on October 28, 1982, the parties stipulated that the claim was timely filed, that the Claimant was a coal miner, that he worked at least sixteen years at the coal mines, and that he had, at that time, two dependents. The Deputy Commissioner determined that the evidence did not establish either the presence of pneumoconiosis or total disability arising therefrom. There was no request a formal hearing, and the claim was administratively closed. Claimant filed a subsequent application for benefits on March 19, 2002.

Subsequent Claim

In cases where a claimant files more than one claim and the earlier claim is denied, the later claim must also be denied on the grounds of the earlier denial unless there has been a material change in condition or the later claim is a request for a modification. § 725.309(d). Because the Claimant's first claim was denied on January 21, 1980, and became final, the current claim was filed on March 19, 2002, more than one year after the prior denial, so that it must be denied on the basis of the prior denial unless there has been a change in an applicable condition of entitlement pursuant to §.725.309(d)

The Benefits Review Board set forth its definition of "material change of conditions" under § 725.309(d) (2000) in *Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000). In this context, a change in an applicable condition of entitlement is deemed to be tantamount to a material change in conditions under the prior regulations. In *Allen*, the Benefits Review Board held that a claimant must establish, by a preponderance of the evidence developed subsequent to the denial of the prior claim, at least one of the elements of entitlement previously adjudicated against him. Therefore, where the administrative law judge concluded that the newly submitted evidence did not establish the presence of pneumoconiosis, but failed to address the issue of whether the evidence supported a finding that the miner was totally disabled, a ground upon which the prior claim was denied, the administrative law judge's decision was vacated. On remand, the administrative law judge was directed to analyze the newly submitted evidence to determine whether Claimant was totally disabled under §718.204(c) before finding no material change in conditions. Because the prior finding in this case was before the Deputy Commissioner, who found that the Claimant failed to prove the existence of pneumoconiosis or any resulting respiratory disability, the newly submitted evidence must be reviewed to determine whether the Claimant has established either of these above requirements for entitlement.

Determination of Pneumoconiosis

Under § 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with § 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

Dr. Nath interpreted a May 16, 2002 x-ray as negative for pneumoconiosis, classified as 0/1. Dr. Nath is a board-certified radiologist and a B-reader.[2] DX 8. This same x-ray was interpreted as negative by Dr. Wiot, who is also dually qualified. EX 3. Dr. Sargent subsequently reviewed the quality of the x-ray and classified the quality as 1. DX 8. Dr. Ballard interpreted a July 16, 2002 x-ray as 1/0, positive for pneumoconiosis. DX 9. Dr. Ballard is a B-reader. A January 13, 2003 x-ray was interpreted by Dr. Goldstein as negative for pneumoconiosis. EX 1. The record does not disclose whether Dr. Goldstein holds any specific qualifications related x-ray interpretation.

[2] A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United states Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because B-readers are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of physicians without such qualifications. *Taylor v. Director, OWCP*, 9 BLR 1-22 (1986).

The preponderance of negative readings by B-readers and board-certified radiologists substantially outweighs the positive x-ray interpretations of record. Under Part 718, when the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. *Dixon v. North Camp Coal Co.*, 8 BLR 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. *Goss v. Eastern Associated Coal Co.,* 7 BLR 1-400 (1984). Greater weight may be assigned to an x-ray interpretation of a B-reader. *Aimone v. Morrison Knudson Co.,* 8 BLR 1-32 (1985). In the instant case, the only positive reading was rendered by Dr. Ballard, a B-reader. By contrast, Drs. Goldstein, Nath and Wiot found the x-ray evidence to be negative, and Dr. Nath and Dr. Wiot are dually certified.

The record also contains more negative interpretations than positive, and it is within the discretion of the administrative law judge to defer to the numerical superiority of the x-ray interpretations. *Edmiston v. F & R Coal Co.,* 14 BLR 1-65 (1990). Consequently, I find that the preponderance of the x-ray evidence, as reviewed by several B-readers and board-certified radiologists, fails to establish the existence of pneumoconiosis under § 718.202 (a)(1).

Pursuant to § 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

Section 718.202(a)(3) provides that it shall be presumed that the miner was suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305 or 718.306 are applicable. Section 718.304 is not applicable because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Section 718.306 is inapplicable because it pertains only to claims of miners who died on or before March 1, 1978.

Section 718.202(a)(4) provides that a physician, exercising sound medical judgment, notwithstanding a negative x-ray, may find that the miner has pneumoconiosis. Any such finding must be based upon objective medical evidence and be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.,* 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Id.* Upon review of the medical opinion evidence, I find that the better-reasoned and better-documented reports of record establish that legal pneumoconiosis is present.

Dr. Shad examined the Claimant on May 16, 2002. He recorded that the Claimant worked as a coal mine inspector from 1970 to 1982. He further recorded a smoking

history of only two years. The Claimant reported dyspnea, so that walking was limited to 100 feet. Dr. Shad reported a normal examination of the thorax and lungs. The chest x-ray conducted was negative for pneumoconiosis and the arterial blood gas study was normal. The pulmonary function study showed mild obstructive lung disease. Dr. Shad opined that the Claimant has pneumoconiosis based on his chest x-ray. He further diagnosed obstructive lung disease based on the pulmonary function study. He opined that the pneumoconiosis and obstructive lung disease were both due, in part, to the Claimant's coal dust exposure, and that the pneumoconiosis and obstructive lung disease "are the main contributors to pulmonary impairment." DX 8.

Dr. Hawkins provided a medical report dated July 30, 2002, in which he opined that the Claimant has coal workers' pneumoconiosis. This report was written after Dr. Hawkins performed a physical examination and reviewed the Claimant's positive chest x-ray interpretation, pulmonary function results, and arterial blood gas results. Dr. Hawkins noted an eleven year coal mining history working as a mining inspector, and a history of ischemic heart disease, coronary artery disease, Parkinson's disease, peptic ulcer disease, psoriasis, hyperlipidemia, and mild obesity. He reported symptoms of exertional dyspnea, chronic coughing, and sputum production. Dr. Hawkins opined, "Mr. Whalen is clinically impaired with recurrent history of exposure of coal dust. His chest x-ray is compatible with coal workers' pneumoconiosis, although pulmonary function studies demonstrated no significant impairment, and resting and exertional blood gases also demonstrate adequate gas exchange." DX 9.

Dr. Goldstein examined the Claimant on January 13, 2003. He reported that the Claimant worked in the underground coal mining industry from 1953 through 1970, and that the Claimant only smoked two years, having quit over 33 years before the examination. Dr. Goldstein performed a physical examination of the Claimant, noting an occasional wheeze that totally clears with cough. He noted that the Claimant's EKG showed an old anterior myocardial infarction, with PA and lateral chest x-rays showing the heart to be slightly full. The chest x-ray did not show evidence of any nodules consistent with coal dust exposure. Dr. Goldstein conducted arterial blood gas and pulmonary function studies. The pulmonary function study showed a mixed restrictive and obstructive disease by pulmonary function. Dr. Goldstein was also provided with the Claimant's medical records, including records from Drs. Hudson, Hawkins, and Shad, which documented mild obstructive airways disease and significant coronary disease.

Based on the objective studies, physical examination, and medical records, Dr. Goldstein diagnosed coronary artery disease, hypercholesterolemia, peptic ulcer disease, Parkinsonism, psoriasis, degenerative joint disease, chronic shortness of breath and chronic cough. In addition to the negative chest x-ray, Dr. Goldstein reported that the spirometry suggested a restrictive and obstructive defect. Lung volumes were normal to slightly hyperinflated. He noted that the Claimant's shortness of breath had progressed for the last ten years, having begun after the Claimant was out of the coal mines for ten

years. He noted that the Claimant's symptoms were most consistent with congestive heart failure, and likely due also in part to the Claimant's obesity and progressive Parkinsonism. In sum, Dr. Goldstein opined that the Claimant does not have pneumoconiosis, and made no finding as to whether the Claimant is totally disabled due to any respiratory impairment. EX 1.

Dr. Friedlander reviewed the Claimant's medical records and provided a report dated February 22, 2004, which primarily focuses on whether the Claimant's exposure to coal dust has contributed to any respiratory impairment. However, Dr. Friedlander provided the following opinion with respect to the existence of pneumoconiosis:

> Although conventional wisdom is that exposure to coal dust does not produce measurable obstructive changes in the absence of major changes on x-ray, today's evidence and an understanding of the pathology have satisfied me that this is simply not true. I agree with Dr. Hawkins and the USDL examiner who believe that coal dust is present in the lungs and producing a mild obstructive lesion. The history supports this, and so does the spirometry, especially the minimally increased total lung volume and mild decrease in forced expiratory volumes .... I have no other explanation for the obstructive lesion on spirometry, except for the dust exposure.

EX 2, p.4.

Dr. Friedlander further opined that, based on his review of the Claimant's medical records, the Claimant's coal dust exposure is not contributing at all to his present disability. Rather, he attributed any present disability to his obesity and ischemic damage to his heart. Dr. Friedlander did not specifically address whether the Claimant's respiratory impairment precludes him from returning to the coal mining industry. EX 2.

Initially, Dr. Hawkins' diagnosis of pneumoconiosis appears to be based predominantly on Dr. Ballard's positive chest x-ray interpretation. A diagnosis or medical opinion which is merely a restatement of a positive x-ray is not a reasoned medical opinion within the meaning of § 718.202(a) (4). *See Worchach v. Director, OWCP*, 17 BLR 1-105 (1993). A medical opinion that purports to be based on clinical findings beyond the x-ray reading may be found to be based solely on the x-ray reading. *See Taylor v. Brown Badgeet, Inc.*, 8 BLR 1-405 (1985). As Dr. Hawkins gives no rationale for his diagnosis of pneumoconiosis other than the positive chest x-ray readings, I find his report to be poorly documented, poorly reasoned, and entitled to little weight.

I find the opinion of Dr. Shad to be poorly reasoned with respect to his finding of clinical pneumoconiosis,. The only explanation noted related to a chest x-ray. As there

is inadequate documentation or reasoning associated with this diagnosis, it has little probative value. However, Dr. Shad also diagnosed obstructive lung disease based on the Claimant's pulmonary function studies, and opined that this disease was the result of both the Claimant's limited smoking history and his exposure to coal dust. This finding was consistent with that of Dr. Friedlander, who agreed that coal dust is present in the lungs and has produced a mild obstructive lesion.

Pursuant to § 718.201, "legal pneumoconiosis" includes any chronic lung disease or impairment arising out of coal mine employment. This definition includes any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. Dr. Friedlander's and Dr. Shad's diagnoses of obstructive lung disease due, in part, to exposure to coal dust constitute diagnoses of legal pneumoconiosis. Both physicians' opinions rest on the Claimant's spirometry results and length of coal mining employment, notwithstanding his limited smoking history. Particularly persuasive is Dr. Friedlander's report, which notes that there is no other explanation than coal dust exposure for Claimant's documented minimally increased total lung volume and mild decrease in forced expiratory volumes.

Dr. Goldstein addressed the Claimant's spirometry results, stating that the Claimant's obstructive airways disease is unrelated to coal dust. He noted, "With the symptomatology that he has, one would expect his chest x-ray to be significantly abnormal if it were related to coal workers' pneumoconiosis." Although the absence of findings on a chest x-ray may be significant in the diagnosis of clinical pneumoconiosis, it is not inconsistent with a finding of legal pneumoconiosis. As Dr. Goldstein's report does not adequately address the existence of legal pneumoconiosis, I find that it does not outweigh the opinions of Dr. Friedlander and Dr. Shad. Thus, the newly submitted evidence establishes a change in the Claimant's condition, and so the record must be reviewed as a whole to determine whether the evidence, as a whole, establishes the existence of pneumoconiosis.

In relation to the prior claim, hospital and medical treatment notes were submitted. DX 1. These records have been reviewed, but do not directly address the existence of pneumoconiosis, and so have little probative value in this case. Four x-ray readings were previously considered, including a July 25, 1980 x-ray interpreted as negative by Dr. Gonzalez and by Dr. Elmer, a July 1, 1981 x-ray interpreted as negative by Dr. Branscomb, and a September 29, 1981 x-ray interpreted as negative by Dr. Branscomb. Additionally, the record contains a number of reports based on chest x-rays taken from 1977-1981. These x-ray interpretations were not conforming with respect to the ILO-U/C classification system, and do not establish pneumoconiosis pursuant to § 718.202(a)(1).

Dr. Tai examined the Claimant on August 19, 1980, and diagnosed questionable coronary heart disease, mild obesity, and questionable COPD. He declared, "I do not

consider this man's condition to be secondary to dust exposure." It does not appear that Dr. Tai conducted any chest x-ray, pulmonary function study, or arterial blood gas study. Therefore, I find his report poorly documented. Additionally, as the examination occurred over 25 years ago and in light of the progressive nature of pneumoconiosis, I find this report to be of little probative value.

Therefore, I find that the newly submitted evidence, when considered in conjunction with the prior evidence of record, establishes the existence of legal pneumoconiosis. Specifically, I rely on the opinion of Dr. Friedlander, as supported by that of Dr. Shad. As the existence of legal pneumoconiosis has been established, the Claimant must prove total disability resulting therefrom in order to establish eligibility for black lung benefits.

Total Disability

Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or to engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b)(1)(i) and (ii). Total disability can be established pursuant to one of the four criteria in § 718.204 (b)(2), or the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b)(1). The presumption is not invoked in this case because there is no x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence suggesting complicated pneumoconiosis.

Section 718.204(b)(2)(i) provides for a finding of total disability where pulmonary function tests demonstrate FEV1[3] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[4] or MVV[5] values equal to or less than the applicable table values in the regulations. Alternatively, a qualifying FEV1 reading together with an FEV1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. Section 718.204(b)(2)(i) and Appendix B.

There were no valid qualifying pulmonary function studies submitted as part of the Claimant's initial 1980 claim. After the second application for benefits was filed, pulmonary function studies were conducted on May 16, 2002, and July 30, 2002, which were nonqualifying, and on January 13, 2003, which were qualifying. I find that the January, 2003 qualifying study is outweighed by the two nonqualifying studies done in

[3] Forced expiratory volume in one second

[4] Forced vital capacity

[5] Maximum voluntary ventilation

May and July, less than a year prior. The May and July studies show relatively consistent results, as compared to the outlier results produced in January. There is no evidence or explanation suggesting what may have caused the sudden decrease in pulmonary function exhibited in the January results. Without further explanation about this dramatic shift, I rely on the earlier but more consistent findings of the May and July studies.

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO2 to pO2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from the Claimant's lung alveoli to his blood. § 718.204(b)(2)(ii) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following Part 718 of the regulations.

The valid arterial blood gas study submitted in the initial claim was interpreted as normal. Since then, three blood gas studies have been submitted, dated May 16, 2002, July 2, 2002, and January 13, 2003. None of these studies produced qualifying results. Therefore, I find that the blood gas study evidence of record does not establish total disability under § 718.204(b)(2)(ii). Total disability under § 718.204(b)(2)(iii) is inapplicable because there is no evidence of cor pulmonale with right-sided congestive heart failure.

Finally, the Claimant has not established total disability under § 718.204(b)(2)(iv). Where total disability is not established under § 718.204(b)(2)(i), (b)(2)(ii) or (b)iii), § 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable gainful work. The medical opinion evidence of record does not support a finding of total disability.

Dr. Tai's August 18, 1980 medical report does not include any reference to a disabling pulmonary impairment. Dr. Shad's June 3, 2002 report indicates with respect to impairment, "Patient has impairment on pulmonary function test. Pneumoconiosis and obstructive lung disease are the main contributions to pulmonary impairment." But Dr. Shad did not provide any opinion as to whether the Claimant's pulmonary impairment precludes him from engaging in his usual coal mine work or comparable gainful work.

Dr. Hawkins' July 30, 2002 report states that the Claimant is "very limited with exertional dyspnea, chronic coughing, and sputum production. Mr. Whalen is clinically impaired with recurrent history of exposure of coal dust." However, this report goes on to state that the "pulmonary function studies demonstrated no significant impairment and resting and exertional blood gases also demonstrate adequate gas exchange."

Dr. Goldstein's January 13, 2003 report indicates that the Claimant has chronic shortness of breath and chronic cough, although unrelated to pneumoconiosis. Dr. Goldstein's pulmonary function studies showed mixed restrictive and obstructive disease by pulmonary function. He noted that the medical records further document mild obstructive airways disease, as well as significant coronary disease. But he provided no express statement with respect to whether the Claimant's respiratory condition would preclude him from working in the mining industry or in comparable positions.

Dr. Friedlander's report, dated February 22, 2004, discusses the Claimant's symptomatology and level of disability. He reported the Claimant's complaints of shortness of breath and poor exercise tolerance. He further specifically addressed the Claimant's disability with respect to his pulmonary function, stating,

> There is nothing to suggest that this slightly diminished ability to move air rapidly out of the lungs [referring to his spirometry results] has ever interfered with Mr. Whalen's life or activities. The blood gas levels show that his blood is perfectly well-oxygenated and that he even increases it when he exercises. The lungs have tremendous reserve. Mild obstruction is no problem for an ordinary life ... If Mr. Whalen were a competitive speed athlete, his coal dust would interfere with his winning marathons. But this isn't the issue. Today Mr. Whalen cannot exercise much because of a failing heart, and the fact that his lungs are no longer those of an elite athlete is irrelevant.

EX 2.

I grant Dr. Shad's opinion less probative value as it does not get to the heart of the issue: whether Mr. Whalen's pulmonary impairment is totally disabling. Although he reports a pulmonary impairment, he provides no description as to the extent of impairment.

Similarly, Dr. Hawkins reported that the Claimant was "very limited" with respect to his symptoms and that coal dust exposure produced a "clinical impairment," but he provided no opinion with respect to the extent of the impairment. In fact, he declared that the pulmonary function study "demonstrated no significant impairment," and that the blood gas study "demonstrate[d] adequate gas exchange." Consequently, I find that his opinion does not constitute a finding of total disability.

Dr. Goldstein is the only physician who relied upon qualifying pulmonary function studies. Although he noted the spirometry results, he further noted that the Claimant's shortness of breath is more consistent with congestive heart failure. He provided no opinion with respect to whether the Claimant is totally disabled due to a respiratory impairment.

The evidence presented clearly suggests that the Claimant is significantly impaired. He testified that he needed help to dress and bathe. He further testified that he is unable to walk uphill at all. It is also telling that Dr. Goldstein opted not to test the Claimant's pulmonary function while exercising due to the Claimant's history of angina and Parkinsonism. Based on the medical records and the Claimant's testimony, I find that it is more probable than not that the Claimant is totally disabled. However, the Act requires that total disability must be due to the Claimant's respiratory or pulmonary condition.

I find that Dr. Friedlander's report is most probative as to whether the Claimant's disability is pulmonary or respiratory in nature. Dr. Friedlander found that the Claimant's mild obstruction is not the result of the Claimant's disability, but rather his exercise intolerance and shortness of breath are related to his failing heart. Moreover, the Claimant obviously is restricted as a result of his progressive Parkinsonism. Neither of these conditions results in a disabling pulmonary impairment.

Thus, although the Claimant is probably significantly impaired, the medical evidence of record does not support a finding that he is totally impaired due to his pulmonary or respiratory condition. Consequently, I find that the Claimant has not established the existence of a totally disabling respiratory impairment pursuant to § 718.204(b)(2)(iv).

Total Disability Due to Pneumoconiosis

As the Claimant has failed to establish a total disabling respiratory impairment, he has also failed to establish total disability due to pneumoconiosis pursuant to § 718.204(c)(1). Total disability due to pneumoconiosis requires that pneumoconiosis, as defined in § 718.201, be a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Substantially contributing cause is defined as having a "material adverse effect on the miner's respiratory or pulmonary condition," or as a cause which "materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment." § 718.204(c)(1).

The evidence of record does not establish that the Claimant is totally disabled due to pneumoconiosis pursuant to § 718.204(b)(2). There is no evidence of cor pulmonale or evidence satisfying the presumptions of § 718.305. Therefore, total disability due to pneumoconiosis musts be demonstrated by documented and reasoned medical reports. No physician of record has found that the Claimant is totally disabled due to pneumoconiosis. For the reasons stated above, I rely on the opinion of Dr. Friedlander, as supported by Dr. Goldstein, in finding that the Claimant's impairment is related to cardiac disease, obesity, and progressive Parkinsonism. This explanation outweighs the

opinions of Drs. Shad and Hopkins, neither of which provided unequivocal reports finding total disability due to pneumoconiosis. Therefore, the Claimant has not established the requisite causal nexus between his legal pneumoconiosis and his total disability.

Entitlement

The Claimant has established a change in condition since his prior denial in 1980. Based on the newly submitted medical records, considered in conjunction with the reports submitted in 1980, I find that the Claimant has established the existence of legal pneumoconiosis. However, I find that the record fails to establish that the Claimant is totally disabled due to his respiratory or pulmonary condition. As the Claimant has not established total disability attributable to pneumoconiosis I find that he is not entitled to benefits under the Act.

ORDER

The claim of Clarence E. Whalen for benefits under the Act is denied.

A

Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).